County of Santa Barbara
Department of Behavioral Wellness

Request for Change of Care Provider/Clinician

How to complete this form: Please complete this form with the information requested and mail it or give it to your Care Coordinator or the front desk staff at your provider's location.

Date of Request: _____

I wish to request a change in provider/clinician: _____
(name of person currently providing services)

for the following reasons (optional):

I have discussed this request with my current clinician: ☐ Yes ☐ No

My phone number: _____

Print Name: _____ Signature: _____

THIS SECTION TO BE COMPLETED BY BEHAVIORAL WELLNESS SERVICES STAFF

Date: _____ **To:** _____

_____
(consumer's name)

Your request was reviewed by: _____

A decision was made to provide requested provider change: No Yes Effective Date: _____

If no, Reasons were: _____

_____

_____

This response was provided ☐ by telephone ☐ in writing on date _____

by _____

If you wish to appeal the above decision, sign below and return this form to the address listed below. Appeals will be treated as Formal Grievances. Please refer to your Member Services Brochure for more information.

☐ I do wish to appeal the above decision.

Signature: _____ **Date**: _____

Mail this form to: **Beneficiary Concerns, 315 Camino Del Remedio #257 Santa Barbara, CA 93110**